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Understanding Primary Care Providers' Perceptions and Practices in Implementing Confidential Adolescent Sexual and Reproductive Health Services

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Abstract

Purpose: Substantial gaps exist between professional guidelines and practice around confidential adolescent services, including private time between health-care providers and adolescents. Efforts to provide quality sexual and reproductive health services (SRHS) require an understanding of barriers and facilitators to care from the perspectives of primary care providers working with adolescents and their parents.

Methods: We conducted structured qualitative interviews with a purposive sample of pediatricians, family physicians, and nurse practitioners (n = 25) from urban and rural Minnesota

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communities with higher and lower rates of adolescent pregnancy. Provider interviews included confidentiality beliefs and practices; SRHS screening and counseling; and referral practices.

Results: The analysis identified two key themes: (1) individual and structural factors were related to variations in SRH screening and counseling and (2) a wide range of factors influenced provider decision-making in initiating private time. A nuanced set of factors informed SRHS provided, including provider comfort with specific topics; provider engagement and relationship with parents; use of adolescent screening tools; practices, policies, and resources within the clinic setting; and community norms including openness with communication about sex and religious considerations regarding adolescent sexuality. Factors that shaped providers' decisions in initiating private time included adolescent age, developmental stage, health behaviors and other characteristics; observed adolescent-parent interactions; parent support for private time; reason for clinic visit; laws and professional guidelines; and cultural considerations.

Conclusions: Findings suggest opportunities for interventions related to provider and clinic staff training, routine communication with adolescents and their parents, and clinic policies and protocols that can improve the quality of adolescent SRHS.

Multiple professional societies recommend that adolescents have periodic preventive visits during which they receive confidential services including age-appropriate sexual and reproductive health services (SRHS) [1–5]. In the United States, most adolescent preventive visits take place in primary care settings [6]. Despite the existence of authoritative professional guidelines and evidence demonstrating benefits of adolescent preventive care including quality SRHS [7–9], substantial numbers of U.S. youth do not receive clinical preventive services [10–20]. For example, the 2012–2014 Medical Expenditure Panel Survey estimated that only 48% of U.S. 10- to 17-year-olds had a preventive visit in the past year [20].

Adolescence is a period that includes simultaneously renegotiating boundaries with parents, navigating the new terrain of intimate relationships and learning to use health-care systems. Primary care providers, including pediatricians, family physicians, and nurse practitioners, are ideally situated to address these critical developmental transitions during preventive visits, as most adolescent preventive visits happen in primary care settings. In primary care, quality SRHS for adolescents includes provision of private time for adolescents with their providers, education of adolescents and parents about confidentiality, developmentally appropriate screening and counseling, and provision of biomedical services such as vaccines, STI testing, condoms, and hormonal contraception [21].

While confidentiality is central to all health-care services, it is especially important in the delivery of SRHS to adolescents. Multiple studies suggest that confidentiality practices, including private time, increase the likelihood of screening and counseling adolescents around potentially sensitive topics related to their sexual and reproductive health [22]. Yet, many youth report not having private time or confidential discussions with their primary care providers [23]. When sexual and reproductive health screening and counseling are included in an adolescent preventive visit, research suggests that the amount of time for these conversations is brief, averaging around 36 seconds [24] Despite the well-documented importance of confidential SRHS from adolescents' perspectives [22], very little research

has explored actual delivery of these particular services from primary care providers' perspectives.

The current analysis employs data from the Confidential Adolescent Sexual Health Services (CASH), a multi-methods study examining factors that affect delivery of quality, confidential SRHS to adolescents from the perspectives of adolescents, parents and primary care providers. Guided by a triadic framework outlined by Ford et al. [25] (Figure 1), the initial phase of CASH research consisted of in-depth individual interviews with primary care providers, parents, and adolescents to identify barriers and facilitators to confidential adolescent SRHS, with a particular emphasis on interactions between these three stake-holder groups. In the current analysis, the first paper from the CASH study, we examine primary care providers' perceptions and practices related to confidential SRHS for adolescents, including the provision of private time.

Methods

Study design and sample

Data for this analysis come from in-depth qualitative interviews with a purposive sample of primary care providers. We interviewed pediatricians, family physicians, and nurse practitioners from four areas of Minnesota: metropolitan and nonmetropolitan communities in geographic areas with high and low rates of teen birth and sexually transmitted infections [26]. This purposive sample enabled us to examine perspectives from providers in areas with variable rates of adverse adolescent reproductive health outcomes. We intentionally sampled providers working in a range of primary care settings including community-based private practices, hospital outpatient departments, freestanding clinics, and federally qualified health centers. Providers with adolescent medicine specialty training were excluded. Within each area, we worked with the Minnesota Department of Health and existing networks of pediatricians, family physicians, and nurse practitioners to identify primary care providers whose practices included adolescents. We invited potential study participants by phone and email, continuing recruitment until we secured participants representing each discipline in each area of the state. Institutional review boards at collaborating universities approved all study protocols.

The sample included 25 pediatricians, family physicians and nurse practitioners providing primary care to adolescents throughout Minnesota. While our team felt that we reached saturation before 25 providers, we continued interviews until we achieved representation from each discipline in each of the four areas described previously. Providers' experience in primary care ranged from 1 year to 31 years; the percent of adolescents in their patient populations ranged from 5% to 95%. Table 1 describes characteristics of the sample.

Interviews with primary care providers

Because this study also asked providers to nominate adolescents and parents from their practices who could be approached for study interviews, we gained permission from their respective healthcare systems. The timeframe for receiving this permission ranged from several days to several months.

Provider interviews were conducted between February 2018 and January 2019 in person (n = 17) or via telephone (n = 8). Providers gave written informed consent and completed interviews with trained masters- or doctoral-level study staff experienced in conducting qualitative interviews. Interviews ranged from 32–62 minutes (mean = 48.9 minutes). Interviews were digitally recorded and transcribed verbatim. Immediately after the interview, providers filled out a brief demographic survey and nominated teens and parents from their practices for CASH staff to approach for study interviews. Providers received $50 as a token of appreciation for their participation.

Interview guide.—Interviews followed a semi-structured guide developed and pilot tested by study investigators. The guide included questions regarding: practices and perceived importance of private time with adolescent patients; confidentiality in providing preventive services; sexual and reproductive health screening and counseling; provision of biomedical services such as vaccines, condoms, and hormonal contraception; and SRHS referral practices. Prompts encouraged providers to share factors they consider when deciding how to approach these topics, language they might use to address these topics, and how systems facilitate or create barriers in these areas.

Data analysis

Deidentified transcripts were analyzed using thematic analysis [27]. Initially, three senior qualitative researchers (one of whom conducted most of the interviews) reviewed the first eight transcripts, making margin notes to capture and summarize salient content. These team members then generated an initial codebook based on margin notes and the triadic framework guiding the study. Coding in Dedoose Version 8.0.44 allowed for simultaneous coding by researchers across sites and permitted team-based construction of coding hierarchies and definitions. Two analysis team members applied initial primary coding to each transcript. A senior team member completed secondary coding and coders reconciled any discrepancies. The qualitative team met regularly and refined the codebook in early stages of coding to capture all relevant content in the data and ensure continued coding consistency. After coding was completed and themes identified, tables of quotes within each theme were created to examine influences on variations in providing SRHS and on decision-making regarding provision of private time.

Trustworthiness of data and results were increased through triangulation of data sources [28]. By purposively sampling providers from three primary care disciplines, in four distinct areas of the state, we increased confidence that our findings represent the range of experiences and perspectives of primary care providers in Minnesota. In addition, we debriefed each step of the interviewing and coding process with our larger team, a group from multiple states with diverse expertise related to adolescent SRHS.

Results

We present two key themes regarding providers' perceptions and practices related to quality adolescent SRHS: (1) individual-level and structural factors were related to variations in routine SRH screening and counseling, and (2) a wide range of factors influenced provider decision-making in initiating private time.

Variations in sexual and reproductive health screening and counseling

Variations in routine SRH screening and counseling were influenced by both individual-level and structural factors. In some cases, providers' comfort with topics influenced their approach to SRH screening and counseling. Many stated that issues around sexual relationships, sexuality, sexual and gender identity were the most challenging. When asked about which topics they were least comfortable discussing, one family physician stated *"…the relationships, the sexual decision-making, that stuff I don't bring up as often and is a little bit tougher to talk about with the 15-year-old that I don't see that often."* Similarly, a family nurse practitioner noted, *"…least comfortable, probably sexual identity and orientation. You just have to [broach] that a little bit cautiously because you don't want to offend people…but it's got to be said so I suppose that's definitely the hardest for me personally."*

Critically, some providers discussed that using laws/guidelines helped them overcome their own discomfort discussing certain topics, with one family physician saying, "*I try to follow [minor consent laws about confidentiality], and it makes it easier to put aside my own personal uncomfortableness."*

Many providers described the utility of screening tools and questionnaires. For some providers, these tools normalized questions about SRH topics.

> It actually is built in the EMR, which during the physical it's always asked. It asks about sexuality. […] 'Do you do any contraception?' and then the last question is 'what is your preference?'…and in the question–correct gender preference and that is done just like, you're asking a question."
>
> (Family Physician)

Other providers noted using screening tools to identify red flags.

> Red flags–meaning they identify that they're sexually active [or] they have a concern about something with their genitalia. [Or] they identify on the form that they smoke or drink alcohol or have tried drugs. I'd like to talk about it with them first rather than bringing it up in front of their parent because you get a lot more honest answers."
>
> (Pediatrician)

Providers described challenges that come with parent engagement and difficulties in keeping services confidential, especially with the use of electronic health records. The ways in which providers navigated potentially competing priorities of parent engagement and confidential services led to variation in SRHS.

> But there is some pushback from parents recently about being able to continue to have access to their child's MyChart in the 13-to-18 range. That means they can see everything. The after-visit [summaries], I sometimes would print out and give to the child and say, 'this is for you. You are not going to show this to your mom because we're talking about whatever."
>
> (Pediatrician)

Clinic practices, policies, and resources, including those related to confidentiality and referral, were cited as critical factors influencing provision of SRHS. Providers discussed what they do when their clinic does not offer a service and how it differs based on the type of clinic and resources available:

> So birth control, we have depo, the pill, the ring, the patch. Two of my partners do IUDs and Nexplanon. I'm going to go re-train for IUDs in April. That's my regular clinic. And my free clinic, we don't do the long-acting because we just–it's free. I don't have the money to do that. But I have typed-out forms of the clinics around that can do that and information about the family planning clinics, so even if they don't have insurance, they can get that for free."
>
> (Family Physician)

Not all providers were clear on what their clinic offered or clinic policies regarding adolescent SRHS, which they acknowledged as a barrier to providing consistent services. When asked if adolescents needed parental permission to be seen at their clinic, one pediatrician was unsure, saying: "*probably have to ask the front desk. It's a really good question because they shouldn't have to have approval for that…*" There was also discomfort with referral or billing negatively impacting confidentiality, with one family physician underscoring "*we would try to keep it confidential… once you start doing referrals a lot of times then the bill is going to come back to your parent. So sometimes it's about having that conversation and saying, 'before this bill gets to your house they're going to need to know.'"*

Some providers discussed the impact of their patients' cultures on the provision of SRHS.

> Within the area, there's a fairly strong religious demographic. So I think a lot of them are not always really happy about sex and sexuality. We see that in a lot of parents who either don't want to discuss or don't want to have their kids get the HPV [vaccine]."
>
> (Pediatrician)

Others discussed the influence of their own cultural backgrounds.

> "I think the first thing is getting over my own upbringing and bias. […] Sexuality and drug use was not something we talked about. My parents bought me a book and they said, 'If you have questions, we'll buy you another book'….so how do I go from that for 25–30 years to all of a sudden now I'm supposed to be this expert for youth and talking about sex and making it no big deal? When it was a huge deal–so that's going to take time…"
>
> (Pediatrician)

Provider decision-making regarding private time

Providers discussed a complex set of factors that influenced their decision-making around how and when they initiate private time with adolescents and their parents. These factors included often-informal assessments of patient and visit characteristics.

Adolescent characteristics were often cited as influencing providers, especially the age and maturity of adolescent patients. While some providers mentioned initiating private time at a standard age, most described how their perceptions of adolescent maturity contributed to variation in timing:

> I start thinking about [introducing private time] at 11 – at least by age 13, 14 I'm doing it on everybody. And it depends on the kid–between kind of 11 and 14 I try to judge how mature they look, if I really need to do it or not…you get a 12-year-old who has gone through puberty they might have already been thinking about some of these things. But definitely by 13 or 14 I'm doing it for every kid."
>
> (Family Physician)

Providers also discussed using their knowledge of patient and family history to guide how they introduce private time and what topics they discuss during that time (Table 2).

The reason for an adolescent's clinic visit influenced if and how the providers introduced private time (Table 2). One family nurse practitioner stated, *"It also depends upon the topic, the chief complaint. So kids who are coming in with specific questions related to sexuality… then I always ask for time alone."* Providers also discussed reading between the lines of adolescent requests or responses in front of their parents and offering private time when they suspect an adolescent wants to say more.

Providers noted using observations of parent and adolescent interactions or health concerns expressed by a parent to determine when to introduce private time.

> I [introduce private time] rarely for 12-year-olds, for seventh grade physicals, very rarely will I do that. And usually I would do it depending on the flow of the visit and what I'm noticing between interactions of parent and early adolescent."
>
> (Pediatric Nurse Practitioner)

Some providers discussed how parent characteristics of being "open" with their child can lead them to be more likely to facilitate a conversation about sensitive topics between the parent and adolescent (Table 2).

Providers also gauged and took into account parents' level of understanding and support for private time (Table 2).

> Most [parents] just start packing up their stuff and heading out the door like it's not a big deal. Some people just kind of look at me and do not move and that means they need a little more information and I'm like "oh this is the thing I do I start doing it at this age and you know it's blah, blah, blah and bodies are growing and changing." I also usually for years at that point have set up expectations.
>
> (Family Physician)

Some providers discussed a lack of familiarity with confidentiality laws and professional guidelines, which likely influences discretion in providing private time (Table 2). A family physician stated, "*I'm not probably as familiar as I should be. I mean I know the–I know mostly because of the proxy stuff that above the age 14 and some of the details there…"*

Finally, providers discussed the impact of culture or how cultural differences affect their approach to private time (Table 2). One pediatric nurse practitioner mentioned how she alters her approach when seeing an adolescent from a specific population:

> I have a lot of 20, 21-year-olds particularly Somali teens who don't really necessarily feel the need to disconnect nor want to. Usually I do [ask] them to anyway, but it's a different approach…and it depends how long they've been here. If they were born here, it's probably a little bit different but if they've immigrated more recently it's a very threatening thing to have your parent removed from the room and vice versa.

Discussion

This study explores primary care providers' perceptions and practices related to provision of quality adolescent SRHS. Findings indicate that a confluence of factors impact provision of SRHS to adolescents as well as the initiation of private time, a confidentiality practice known to increase the likelihood of screening and counseling adolescents around sexual and reproductive health [29,30].

Several similar factors contributed to both provision of SRHS and to providers' practice of introducing private time, including provider comfort; practices, policies, and protocols of the primary care setting; and culture and beliefs of both providers and families. Regarding comfort with sexual and reproductive health topics, providers commonly expressed being least comfortable screening and counseling adolescents on healthy relationships, sexual decision-making, sexual orientation, and gender identity. Providers often reported being most comfortable discussing topics of puberty, pregnancy, and STD prevention, areas in which they had received the most training. Findings regarding discomfort with specific topics are consistent with recent focus groups of primary care providers from 30 states, where providers noted limited confidence addressing SRH topics including sexual orientation and gender identity [31]. These findings suggest important topics to address in training of current and future primary care providers and in professional organizations' practice guidelines.

All proximal interactions around SRHS and private time involved triadic relationships among providers, parents, and adolescents (Figure 1). Providers employed both direct and indirect strategies in working with parents to promote adolescent sexual and reproductive health. For example, some providers noted directly engaging with parents early in preventive care visits regarding the practice and purpose of private time between adolescents and their providers. This strategy is consistent with previous research suggesting that provider communication with parents about confidentiality practices facilitates adolescents' receipt of confidential SRHS [22]. While a study of urban primary care providers found that some providers limited communication with parents about confidentiality to avoid being "confrontational" [15], another study with parents found that provider communication about what to expect during a confidential visit minimized parent concerns [32]. Many providers also described an indirect strategy for working with parents, namely encouraging and facilitating conversations between teens and their parents about relevant sexual and

reproductive health topics. Overall, quality adolescent SRHS are most likely to be delivered when providers are able to successfully navigate potentially competing priorities of parent engagement and confidential services. For primary care providers to function as partners with parents while simultaneously assuring adolescents' rights to confidential services, providers need training and resources to interact with parents around the purpose of confidentiality and private time with adolescents; to encourage teen-parent communication about sexual and reproductive health topics; and to support healthy parent-adolescent relationships.

Interactions between primary care providers, parents, and adolescents occur within the complex context of adolescent health services. Our findings support the notion that a constellation of characteristics—of adolescent patients, their parents, providers, and other clinic staff, primary care settings, and broader policy and social contexts—influence variability in the delivery of adolescent SRHS. This complexity suggests that models accounting for interacting, multilevel influences on health services delivery should be used to guide quality improvement efforts and implementation research related to adolescent SRHS. For example, the Consolidated Framework for Implementation Research specifies potential sources of influence across multiple domains—related to an innovative practice or program, the setting in which it is introduced, the individuals involved, and the process by which implementation is accomplished [33]. Using frameworks that account for multiple determinants to guide implementation of novel evidence-based practices will maximize the likelihood that such practices ultimately translate into meaningful patient care outcomes across settings.

This study has several limitations. As a qualitative study, findings are not intended to represent perceptions and practices of a larger population of primary care providers. Instead, these data provide rich observations regarding factors that may influence the quality of adolescent SRHS and that merit further research. Another potential limitation is that providers' descriptions may not be consistent with what actually happens in their practices due to social desirability bias. However, in these interviews providers were very open about potential areas of improvement in their practices, suggesting honesty in their responses. A third limitation is that this study includes only perspectives of primary care providers. Future analyses of CASH study data will examine adolescent and parent perspectives, to more fully understand barriers and facilitators to confidential adolescent SRHS in primary care settings.

Despite these limitations, our findings can inform development and implementation of strategies to improve the quality of adolescent SRHS in primary care settings. Our findings highlight important opportunities for primary care providers to work with adolescent patients and their parents to improve adolescent sexual health outcomes. Additionally, our data suggest opportunities for interventions related to provider and clinic staff training, routine communication with adolescents and their parents, and clinic policies and protocols that can improve the quality of SRHS for adolescents.

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IMPLICATIONS AND CONTRIBUTION

This study explores primary care providers' practices related to confidential adolescent sexual and reproductive health services. Findings suggest opportunities for interventions related to provider and clinic staff training, communication with adolescents and parents, and clinic policies and protocols that can improve the quality of these services.

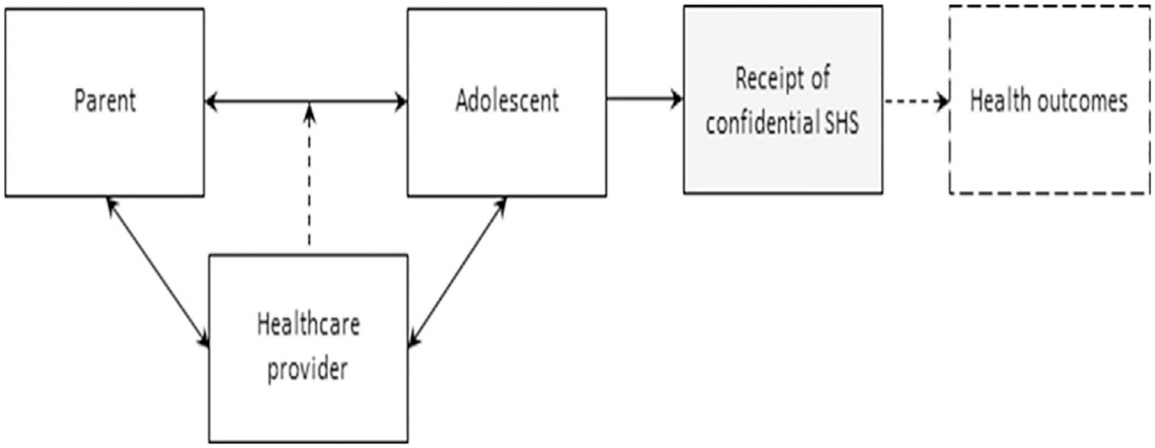

Figure 1.
Triadic relationships and partnerships among providers, parents, and adolescents to promote receipt of confidential adolescent sexual and reproductive health services [25].

Table 1

Characteristics of participating primary care providers (N = 25)

Characteristic	n	%
Age[a]		
30–39 years	10	41.7
40–49 years	9	37.5
50–59 years	2	8.3
60+ years	3	12.5
Gender		
Female	18	72.0
Male	7	28.0
Professional training		
Family medicine	8	32.0
Family nurse practitioner	5	20.0
Pediatrics	7	28.0
Pediatric nurse practitioner	5	20.0
Years in primary care practice[a]		
<10 years	13	54.2
10–20 years	8	33.3
21+ years	3	12.5
Practice settings[a,b]		
Private practice	11	45.8
Hospital outpatient clinic	8	33.3
Freestanding clinic	7	29.2
Community health center	4	16.7
Other	2	8.3
Patient ages, main practice setting[c]		
Majority are ages 0–10 years	10	43.5
Majority are ages 11–19 years	2	8.7
Majority are ages 20+ years	11	47.8
% Adolescent patients, main practice setting[c]		
1%–24%	11	47.8
25%–49%	10	43.5
50% or more	2	8.7

[a]This information was provided by N = 24 providers.

[b]Providers could select more than one practice setting.

[c]This information was provided by N = 23 providers.

Table 2

Factors influencing provider decision-making in initiating private time

Factor	Quotation
Adolescent characteristics	If I know already that a kid is sexually active or if I know that they have a history of substance use or if I know that their family situation is challenging in a certain way or they have depression. I will typically start with the things that I know and probe around that just because I anticipate that being the bigger issue. otherwise if I don't know anything going into it I will tell the kid usually just like 'I have a list of questions that I ask everybody but do you have things you want to talk about or ask about first without your parent in the room?" -Pediatrician
Reason for visit	"For kids coming in with concerns about acne, and they specifically request birth control or they ask about it, I'll usually have parents step out for that. Usually it's ok actually need birth control for, birth control not for my acne, or maybe in addition to my acne. So that's an example – for kids that come in with cold or other things, I don't usually have parents step out for that." -Family Nurse Practitioner
Adolescent-parent interactions	"I had a handful of patients where parents know their kids are sexually active or knows […] they're having suicidal thoughts and for those it's helpful to have – it works better when parents and the teens talk to each other. And for that I will sometimes make an exception for that. But I do always offer and I'd say except for those rare occasions where the teens and parents are really 100% transparent I always do them separate." -Pediatrician
Parent understanding and support of private yime	Well I think we've been doing it long enough that parents expect it and say, "When are you going to let me go?" Sort of sometimes for the parents. In the beginning, it was always a challenge; you'd have to have all the conversation blah, blah, blah and now really rarely do I need that anymore. Just the grandma last week is the only one that I've had for a long time; I was shocked and I thought, "Okay now I have to think about what I have to say now" because I haven't had to do that for a really quite a while. […] Some of them will ask why and I'll tell them why, and if they don't want me to do it, then I don't. -Pediatric Nurse Practitioner
Laws and professional guidelines	I just have to say that's confidential and I can't tell you, legally, I can't talk to you about that. So usually they're fine with it, they don't press the issue really. I say 'you can always talk to your child about that but I can't talk to you about that.'" -Family Nurse Practitioner
Impact of culture	I say that the things that we talk about in this room are confidential and I often – so I'm using a scribe right now because I have some disability accommodations that allow me to use a scribe and that counts for her too or I'll say it like sometimes I've heard that there's fear that the interpreters are going to share information because they live in the same community or possibly in the same building and even I've had that concern before because I've had some looser-lipped interpreter experiences where I'll say it to the interpreter and the patient kind of both. I mean I'm saying it to the patient but I'm really intending to communicate it to the interpreter that this is a legally protected confidentiality space and so I find that to be really useful. I don't know if it actually works but I find it – I think it does…" -Family Physician